State of California
Work and Family Program
Form DPA-684

DEPENDENT CARE BENEFIT APPLICATION

FlexElect Employer Contribution For the 2004 Plan Year

SECTION A

EMPLOYEE NAME (Please clearly print in blue or black ink)			**SOCIAL SECURITY #**
(Last) 1	(First) 2	(MI) 3	4 - -

MAILING ADDRESS Street 5	City 6	State 7	Zip 8

DAY TELEPHONE # 9 ( )	**Ext.** 10	**EVENING TELEPHONE #** 11 ( )

DEPARTMENT/AGENCY (In addition, specify the location where you work if your Dept/Agency has more than one location.) 12, 13	14 **BARGAINING UNIT #**

SECTION B

YOUR CURRENT ANNUAL BASE SALARY	**YOUR E-MAIL ADDRESS**
$	

***LEVEL OF BENEFIT YOU NEED (UP TO $1,000).**

$ _____

***Contact your personnel office, union representative or employee organization to determine if you qualify for this benefit.**

Unclaimed funds are subject to forfeiture in the FlexElect account, so carefully estimate your dependent care expenses for the year and only choose the amount you need.

SECTION C

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❑ Check here if you meet the requirements for a federal tax credit for "Child and Dependent Care Expenses," described in IRS Publication 503 http://www.irs.gov/pub/irs-pdf/p503.pdf .
(You must meet these requirements even if you do not claim the credit on your tax return. The same requirements are used to determine if the day care expenses you check below will qualify for this State benefit.)

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TYPE OF DEPENDENT CARE EXPENSES THIS BENEFIT WILL PAY FOR:

❑ **CHILD** (child must be under age 13)
❑ **ELDER** (parent must live with you and be your tax dependent)
❑ **DISABLED DEPENDENT**

SECTION D

I wish to apply for the Dependent Care Benefit for the 2004 Plan Year. I certify under penalty of perjury that my **annual base salary for 2003 does not exceed $48,000.**
I understand that:
- ✓ If my application is approved, I must enroll in a FlexElect Dependent Care Reimbursement Account for 2004; and
- ✓ I am fully responsible for the accuracy and completeness of all information requested on this form.
- ✓ Any unclaimed funds are subject to forfeiture in the FlexElect Account.

I have read and agree to all the terms and conditions of the Dependent Care Benefit Program as outlined in the Dependent Care Benefit Program brochure.

➔ **Employee Signature: _____ Date: _____**

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-578) requires that this notice be provided when collecting personal information from individuals. While participation in completing this form is voluntary, please be assured that all information requested on this form will remain confidential, and will be retained at the Department of Personnel Administration for the duration of the Work and Family Program. For further information, please mail your request in writing to: Department of Personnel Administration, Work and Family Program, 1515 S Street, 4th Floor, Suite 400, Sacramento, CA 95814-7243.

Mail this completed form,
POSTMARKED NO LATER THAN SEPTEMBER 12, 2003 to:
DEPARTMENT OF PERSONNEL ADMINISTRATION
WORK AND FAMILY PROGRAM
1515 'S' Street, Suite 400, North Bldg., Sacramento, CA 95814

*FAXED, E-MAILED, or LATE Applications WILL **NOT** BE ACCEPTED.*

Additional information and forms are available at
www.dpa.ca.gov/workingfamilies

Form Completion Instructions

Step 1 - Complete the *Dependent Care Benefit Application* as follows:

Section A: Fill in your name, Social Security number, address, work and home phone number, agency and/or department where you work, and your bargaining unit number.

Section B: Fill in your base annual salary. Fill in the level of benefit you need (up to $1,000 for those who qualify). Fill in your e-mail address if you have one.

Section C: Check the box if you're eligible for a dependent care tax credit on your federal tax return, even if you don't claim it. For information on IRS Publication 503 please visit: http://www.irs.gov/pub/irs-pdf/p503.pdf. If you are ineligible for the tax credit, do not submit this application. (This application requires you to be eligible for a FlexElect dependent care account, which uses the same eligibility rules as the federal tax credit.) Check the box by the type of dependent care expenses this benefit will pay for.

Section D: Sign and date your application after you carefully read the text in section D.

Step 2 - Mail in the form to: Work and Family Program, 1515 'S'. Street, North Building, Suite 400, Sacramento, CA 95814. **Your application must be postmarked by September 12, 2003, to be considered for this special new benefit. Faxed or e-mailed applications will not be accepted.**

Step 3 - We review your application. If you are selected we will contact you during September 2003 and advise you to enroll in the FlexElect program.

Step 4 - **You must submit a separate form** to enroll in FlexElect during the fall 2003 open enrollment period. You will be required to deposit a minimum of $20 per month into the FlexElect Dependent Care Reimbursement Account beginning in January 2004.

Step 5 - After you have enrolled in the FlexElect Dependent Care Reimbursement Account, we deposit a dependent care benefit of up to $1,000 into your FlexElect account.

Step 6 - You submit claim forms and receipts for your dependent care costs to the FlexElect record keeper, and receive reimbursement from your account.

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The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-578) require that this notice be provided when collecting personal information from individuals. Information requested on this form is used by the State Controller's Office and the Department of Personnel Administration for the purpose of identification and document processing within the authority of Government Code Sections 19822.7 and 20963.1.

It is mandatory to furnish all information on this form. Failure to provide the mandatory information may result in your application not being processed. The State Controller's Office requires your Social Security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153.

Copies of your Dependent Care Benefit Application form are retained in confidential files of the Department of Personnel Administration Work and Family Program for the duration of the Work and Family Program. You have the right of access to a copy of your application form upon request. Send a request in writing to: Department of Personnel Administration, Work and Family Program, 1515 S Street, Suite 400, Sacramento, California 95814-7243.